

Away From Home Care Guest Services & Follow-up Care Application

AFHC NETWORK:

- ☐ Standard ☐ GMA/UAW
☐ HMO USA ☐ Ford/UAW
☐ Med Blue ☐ Reciprocity



BlueCross BlueShield Association
An Association of Independent Blue Cross and Blue Shield Plans

A - Subscriber Information

APPLICATION DATE: _____

NAME _____

SOCIAL SECURITY # _____

ADDRESS _____

SEX

MARITAL STATUS

- ☐ Male ☐ Single ☐ Married
☐ Female ☐ Divorced ☐ Other

TELEPHONE # _____

WORK TELEPHONE # _____

DATE OF BIRTH _____

DESCRIBE OTHER _____

EMPLOYER NAME _____

GROUP # _____

EMPLOYER ADDRESS _____

TYPE OF COVERAGE

EMPLOYMENT STATUS

- ☐ Individual ☐ Family ☐ Active ☐ Retired

SUBSCRIBER ID #: _____

B - Guest Member Information

RELATIONSHIP TO SUBSCRIBER:

- ☐ Self ☐ Spouse ☐ Dependent

NAME _____

SOCIAL SECURITY # _____

ADDRESS AWAY FROM HOME _____

SEX

GUEST STATUS

- ☐ Male ☐ Single ☐ Married
☐ Female

TELEPHONE AWAY FROM HOME _____

DATE OF BIRTH _____

GUEST MEMBER ID NUMBER _____

MEDICARE ENROLLEE <input type="radio"/> Yes <input type="radio"/> No	MEDICARE TYPE <input type="radio"/> Traditional <input type="radio"/> Medicare Risk <input type="radio"/> Medicare Cost	MEDICARE # _____ SHOULD HOST DIRECT PATIENT TO PARTICIPATING PROVIDER? MEDICARE <input type="radio"/> Yes <input type="radio"/> No	DRUG CARD NAME: _____ DRUG CARD PHONE: _____
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C - Control Information

PERIOD OF GUEST MEMBERSHIP

FROM: _____ TO: _____

- ☐ New ☐ Renewal

TYPE OF GUEST MEMBERSHIP

- ☐ Families Apart ☐ Student ☐ Long term Traveler ☐ Pre-authorized Follow-up Care

BENEFIT LEVEL

- ☐ High ☐ Low ☐ Medicare

Memo: _____

D - Home HMO Information

HMO CODE: _____

NAME AND ADDRESS: _____

AFHC COORDINATOR

TELEPHONE # _____

PRIMARY CARE PHYSICIAN

TELEPHONE # _____

E - Host HMO Information

HMO CODE: _____

NAME AND ADDRESS: _____

AFHC COORDINATOR

TELEPHONE # _____

PRIMARY CARE PHYSICIAN

TELEPHONE # _____

F - Application Tracking Information

GUEST MEMBERSHIP APPLICATION STATUS: _____

HOME CONFIRMATION SENT TO MEMBER: _____

DATE HOME SENT GMA TO HOST: _____

RENEWAL MEMO SEND TO MEMBER: _____

DATE HOST RECEIVED GMA FROM HOME: _____

MEDICAL RECORD REQUESTED: _____